Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $4,809.92 for date of service 02/28/01.

   b. The request was received on 02/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 05/08/02
   b. HCFA(s)
   c. TWCC 62
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 06/03/02
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 05/22/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 05/24/02. The response from the insurance carrier was received in the Division on 06/03/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

"Recently, we have had an exact case filed with the TWCC Medical Dispute and the judge allowed a total of $6,861.67 for performing the anterior extra peritoneal exposure of vertebral bodiesL5-S1. We are enclosing such findings from the Judge for your review. On the above named patient, (Carrier) has made a $2,256.75 payment. When we first appealed they stated they paid us incorrectly and they should have allowed only $1828.35. Then after we received the "decision and order" from the judge regarding the same insurance and same services, which we forward [sic] the information to them with the corrected modifier to 62 they still denied as maximum allowable."

2. Respondent:

"The provider billed a miscellaneous code CPT 37799-62 to represent an anterior extra-peritoneal exposure of vertebral bodies L5-S1. The Texas Fee Schedule addresses reimbursement of this procedure on pg. 65 E. 2. D. states "When anterior arthrodesis is performed by a different surgeon, both surgeons bill using the anterior arthrodesis CPT modifier –65". Per this rule, (Surgeon) should have billed CPT code 22558-65 which would have reimbursed him as follows:
$2660.00(MAR for CPT 22558) x 75% (for use of co-surgeon modifier 65) = $1995.00."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 02/28/01.

2. The denials listed on the EOBs are "C-THIS PREFERRED PROVIDER HAS AGREED TO REDUCE THIS CHARGE BELOW FEE SCHEDULE OR USUAL AND CUSTOMARY CHARGES FOR YOUR BUSINESS. THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUES AS ESTABLISHED BY (AUDITOR COMPANY)."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
02/28/01	37799-62	$8,500.00	$2,256.75	C, M	DOP	MFG SGR (I)(3) -62 Modifier descriptor	"**Two Surgeons:** Under certain circumstances, the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. In these circumstances, add the modifier "-62" to the procedure code used for reporting services by each surgeon. DOP is required." Medical documentation indicates that the services performed were by a second surgeon, not a co-surgeon, who specializes in vascular surgeries and not orthopedic surgeries. In either of the dispute packets from the provider and carrier there is not a pre-negotiated or reduced amount as listed on the EOB denial? Therefore, additional reimbursement is recommended in the amount of $4,809.92.
Totals		$8,500.00	$2,265.75				The Requestor **is** entitled to additional reimbursement in the amount of **$4,809.92.**

The above Findings and Decision are hereby issued this 24th day of July 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $4,809.92 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 24th day of July 2002.

Carolyn Ollar, R.N., B.A.
Medical Dispute Resolution Officer
Medical Review Division

CO/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.